STATE OF CALIFORNIA-HEALTH AND HUMAN SERVICES AGENCY
DEPARTMENT OF HEALTH SERVICES
GENETIC DISEASE BRANCH

INSURANCE INFORMATION FORM

PATIENT INFORMATION (MOTHER'S INFORMATION IF NEWBORN SCREENING)

1. PATIENT INSURANCE ID NUMBER

2. BIRTH DATE: MONTH /DAY/ YEAR

3. DAY PHONE NUMBER

4. PATIENT SOCIAL SECURITY NUMBER

5. PATIENT LAST NAME

6. FIRST NAME

7. MI

8. PATIENT RELATIONSHIP TO INSURED: SELF SPOUSE CHILD OTHER

9. STREET NUMBER

STREET NAME

APT / SUITE

10. CITY

11. STATE

12. ZIP CODE

13. PATIENT MARITAL STATUS: SINGLE MARRIED OTHER

INSURED INFORMATION - *Complete if the insured person is different than the patient*

14. INSURED LAST NAME

15. FIRST NAME

16.MI

17. SEX

18. INSURED SOCIAL SECURITY NUMBER

19. INSURED ID NUMBER / MILITARY ID NUMBER

20. BIRTH DATE: MONTH /DAY/ YEAR

21. STREET NUMBER

STREET NAME

APT / SUITE

22. CITY

23. STATE

24. ZIP CODE

INSURED EMPLOYER INFORMATION

25. INSURED'S EMPLOYER NAME

26. EMPLOYMENT RELATIVE TO INSURANCE:

INSURED EMPLOYMENT: F/T P/T NONE SELF RETIRED UNKNOWN ON ACTIVE MILITARY DUTY

INSURANCE CLAIMS INFORMATION

27. NAME OF INSURANCE CARRIER OR HEALTH INSURANCE

28. GROUP NAME

29. INSURED'S POLICY GROUP NUMBER

30. STREET NUMBER

STREET NAME

APT / SUITE

31. CITY

32. STATE

33. ZIP CODE

PATIENT'S /AUTHORIZED PERSON'S SIGNATURE: I AUTHORIZE THE RELEASE OF ANY MEDICAL OR OTHER INFORMATION NECESSARY TO PROCESS THIS INSURANCE CLAIM AND ASSIGN PAYMENT OF MEDICAL BENEFITS TO THE GENETIC DISEASE BRANCH, DEPARTMENT OF HEALTH SERVICES, FOR SERVICES RENDERED. I UNDERSTAND AND AGREE THAT I AM RESPONSIBLE FOR PAYMENT.

34. Signed: _____ **35. Date:** MONTH / DAY / YEAR

DHS 4479 (9/01)